

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-024739**

FILED VS JUL 20 1959

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 137-A

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Length of stay in lb <u>6 YRS</u>	c. CITY OR TOWN <u>Springfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>910 E. GRAND</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>910 E. GRAND</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>GARRETT William CARTER SR.</u>			4. DATE OF DEATH Month Day Year <u>July 4 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 30 1899</u>	9. AGE (last birthday) <u>60</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>MANSfield MO.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	

13a. FATHER'S NAME <u>John ALVA CARTER</u>		13b. MOTHER'S MAIDEN NAME <u>Isabelle SUSANNA Cashey</u>		14. NAME OF HUSBAND OR WIFE <u>Blanche</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WWI</u>		16. SOCIAL SECURITY NO. <u>500-01-2021</u>		17. INFORMANT Address <u>Blanche CARTER 910 E. GRAND Springfield MO.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Likely Myocardial Insufficiency</u> DUE TO (b) <u>Likely Coronary Sclerosis</u> DUE TO (c) <u>UNATTENDED BY A PHYSICIAN</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Not known but rather sudden.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE	

21. I attended the deceased from XX and last saw him alive on Approx. 1:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>James R. Amos M.D. Health Officer</u>		22b. ADDRESS <u>Springfield-Greene County Health Dept.</u>		22c. DATE SIGNED <u>7-13-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>July 4, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MANSfield</u>	23d. LOCATION (City, town, or county) (State) <u>MANSfield MO.</u>		
24. FUNERAL DIRECTOR <u>Max &amp; Miller, Mansfield Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>7-13-59</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 22 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Max L Miller

Licensed Embalmer No. 4720

P. O. Address Manassas

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to  
with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.